SAN JOAQUIN GENERAL HOSPITAL

ADDENDUM TO DSRIP FIVE-YEAR PLAN SUBMITTED FEBRUARY 18, 2011

CATEGORY 3: POPULATION-FOCUSED IMPROVEMENT REPORTING MEASURES

APRIL 15, 2011

Patient/Care Giver Experience				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	1. **Undertake the necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8.**	2. **Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme for at least data from the last two quarters of the demonstration year to the State** 3. **Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme for at least data from the last two quarters of the demonstration year to the State** 4. **Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme for at least data from the last two quarters of the demonstration year to the State** 5. **Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme for at least data from the last two quarters of the demonstration year to the State** 6. **Report results of CG CAHPS questions for "Shared Decision making" theme for at least data from the last two**	7. **Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State** 8. **Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State** 9. **Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State** 10. **Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State** 11. **Report results of CG CAHPS questions for**	12. **Report results of CG CAHPS questions for "Getting Timely Appointments, Care, and Information" theme to the State** 13. **Report results of CG CAHPS questions for "How Well Doctors Communicate With Patients" theme to the State** 14. **Report results of CG CAHPS questions for "Helpful, Courteous, and Respectful Office Staff" theme to the State** 15. **Report results of CG CAHPS questions for "Patients' Rating of the Doctor" theme to the State** 16. **Report results of CG CAHPS questions for**

Patient/Care Giver Experience				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
		quarters of the demonstration year to the State	**"Shared Decision making" theme to the State**	**"Shared Decision making" theme to the State**

Care Coordination				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	1. **Report results of the Diabetes, short-term complications measure to the State** 2. **Report results of the Uncontrolled Diabetes measure to the State**	3. **Report results of the Diabetes, short-term complications measure to the State** 4. **Report results of the Uncontrolled Diabetes measure to the State** 5. **Report results of the Congestive Heart Failure measure to the State** 6. **Report results of the Chronic Obstructive Pulmonary Disease measure to the State**	7. **Report results of the Diabetes, short-term complications measure to the State** 8. **Report results of the Uncontrolled Diabetes measure to the State** 9. **Report results of the Congestive Heart Failure measure to the State** 10. **Report results of the Chronic Obstructive Pulmonary Disease measure to the State**	11. **Report results of the Diabetes, short-term complications measure to the State** 12. **Report results of the Uncontrolled Diabetes measure to the State** 13. **Report results of the Congestive Heart Failure measure to the State** 14. **Report results of the Chronic Obstructive Pulmonary Disease measure to the State**

Care Coordination Denominator:

The following are the DPH system primary care clinic(s):

1. *PRIMARY MEDICINE CLINIC; 2. FAMILY MEDICINE CLINIC: 3. CHILDRENS HEALTH SERVICES*

Additionally, in order for there to be consistent reporting across DPH systems, the "past 12 months" for all care coordination measures will be defined as the prior demonstration year (July 1 – June 30 of the prior year).[i]

Preventive Health				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	1. **Report results of the Mammography Screening for Breast Cancer measure to the State** 2. **Reports results of the Influenza Immunization measure to the State**	3. **Report results of the Mammography Screening for Breast Cancer measure to the State** 4. **Reports results of the Influenza Immunization measure to the State** 5. **Report results of the Child Weight Screening measure to the State** 6. **Report results of the Pediatrics Body Mass Index (BMI) measure to the State** 7. **Report results of the Tobacco Cessation measure to the State**	8. **Report results of the Mammography Screening for Breast Cancer measure to the State** 9. **Reports results of the Influenza Immunization measure to the State** 10. **Report results of the Child Weight Screening measure to the State** 11. **Report results of the Pediatrics Body Mass Index (BMI) measure to the State** 12. **Report results of the Tobacco Cessation measure to the State**	13. **Report results of the Mammography Screening for Breast Cancer measure to the State** 14. **Reports results of the Influenza Immunization measure to the State** 15. **Report results of the Child Weight Screening measure to the State** 16. **Report results of the Pediatrics Body Mass Index (BMI) measure to the State** 17. **Report results of the Tobacco Cessation measure to the State**

Preventive Health Denominator:

The following are the DPH system primary care clinic(s):

1. *PRIMARY MEDICINE CLINIC*
2. *FAMILY MEDICINE CLINIC*
3. *CHILDRENS HEALTH SERVICES*

Additionally, in order for there to be consistent reporting across DPH systems, the "past 12 months" for all preventive health measures will be defined as the prior demonstration year (July 1 – June 30 of the prior year).[i]

At-Risk Populations				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	1. **Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State** 2. **Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State**	3. **Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State** 4. **Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State** 5. **Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State** 6. **Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State** 7. **Report results of the Pediatrics Asthma Care measure to the State** 8. **Report results of the Optimal Diabetes Care Composite for at least data from the last two quarters of the demonstration year to the State** 9. **Report results of the Diabetes Composite for at least data from the last two quarters of the demonstration year to the State**	10. **Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State** 11. **Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State** 12. **Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State** 13. **Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State** 14. **Report results of the Pediatrics Asthma Care measure to the State** 15. **Report results of the Optimal Diabetes Care Composite to the State** 16. **Report results of the Diabetes Composite to the State**	17. **Report results of the Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl) measure to the State** 18. **Report results of the Diabetes Mellitus: Hemoglobin A1c Control (<9%) measure to the State** 19. **Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State** 20. **Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State** 21. **Report results of the Pediatrics Asthma Care measure to the State** 22. **Report results of the Optimal Diabetes Care Composite to the State** 23. **Report results of the Diabetes Composite to the State**

At-Risk Populations Denominator:

The following are the DPH system primary care clinic(s): 1. *PRIMARY MEDICINE CLINIC; 2. FAMILY MEDICINE CLINIC: 3. CHILDRENS HEALTH SERVICES*

Additionally, in order for there to be consistent reporting across DPH systems, the "past 12 months" for all care coordination measures will be defined as the prior demonstration year (July 1 – June 30 of the prior year).[ii]

Category 3 Five-Year Incentive Payment Table

	DY 6	DY 7	DY 8	DY 9	DY 10
Category 3					
Patient/Care Giver Experience	$0-	$2,037,750	$2,717,000	$4,075,500	$4,754,750
Care Coordination	$0-	$2,037,750	$2,717,000	$4,075,500	$4,754,750
Preventive Health	$0-	$2,037,750	$2,717,000	$4,075,500	$4,754,750
At-Risk Populations	$0-	$2,037,750	$2,717,000	$4,075,500	$4,754,750

[i] "The past 12 months" is defined as the prior demonstration year (July 1 – June 30 of the prior year) because:

- This definition allows the DPH system's year-end DSRIP report to build on the 6-month DSRIP report by using the same population in the denominator, which is consistent with the program mechanics and therefore, with how the other categories are being reported.
- The visit/admission/discharge in which the numerator event occurred (e.g., LDL recorded, admission for diabetes complications) will have occurred after the 2 visits to primary care, which is consistent with the reason for defining the population as patients for whom the health system has had sufficient opportunity to provide good care and influence good health.

[ii] "The past 12 months" is defined as the prior demonstration year (July 1 – June 30 of the prior year) because:

- This definition allows the DPH system's year-end DSRIP report to build on the 6-month DSRIP report by using the same population in the denominator, which is consistent with the program mechanics and therefore, with how the other categories are being reported.
- The visit/admission/discharge in which the numerator event occurred (e.g., LDL recorded, admission for diabetes complications) will have occurred after the 2 visits to primary care, which is consistent with the reason for defining the population as patients for whom the health system has had sufficient opportunity to provide good care and influence good health.